Moonflower  Psychiatry

# TREATMENT CONSENT

I am providing consent for _____
(*Patient's name*)
to receive treatment for mental health services with the following treatment(s): medical management and/or group or individual psychotherapy.

I understand the following:

- That I have been fully informed about the nature of the treatment, the risks and benefits, and the available treatment options.
- That I have had the opportunity to have all questions answered to my/our satisfaction.
- That this consent is given voluntarily.
- That I am legally competent and have the authority to provide consent for treatment.
- That I have the right to withdraw my consent (must be in writing) for this treatment at any time.
- That withdrawing consent for this treatment will not prejudice my continued treatment relationship with Moonflower Psychiatry, and that I can withdraw consent from certain treatment modalities while continuing to receive others.
- That I have received a notice of Moonflower Psychiatry's privacy practices.
- That I have had the opportunity to sign or revoke a release of information stating who I wish Moonflower Psychiatry to communicate with about my treatment.

_____ Date _____
Patient signature

_____ Date _____
Parent/legal guardian

_____ Date _____
Veronica Johnson, PMHNP

*For blooming in the darkness:*

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